New life or green poultice?

New life for health: the commission on the NHS
Will Hutton, chair
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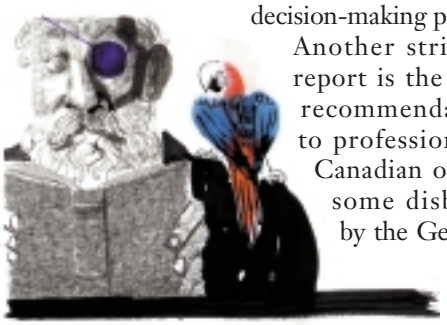
In March 1999, in response to declining public confidence in and rising pressures on Britain's National Health Service (NHS), the Association of Community Health Councils for England and Wales established an independent commission to consider issues of public interest and accountability in the NHS. This commission was chaired by Will Hutton, who was previously the editor of *The Observer*. Hutton's best-selling books, *The State We Are In*, *The State to Come*, *The Stakeholder Society* and, most recently, *On the Edge* (co-edited with Tony Giddons) are widely perceived to be the backbone of New Labour thinking in the UK. The commission report reads with many parallels to the Canadian story, although it is much closer to the traditions associated with the mother of all parliaments.

The report airs a fresh set of ideas for the future of the NHS in Britain: a kind of direct democracy meets the NHS. In a fashion eerily reminiscent of Canada, British newspapers are currently full of stories about health care underfunding and patients on waiting lists for a range of procedures. However, while there are many superficial parallels, there are big differences between the problems of the NHS and those that plague the Canadian health care system. By almost any measure, the UK spends about one-third less than Canada on health care, indeed less than that of most countries in the OECD. The UK nevertheless provides a broader range of coverage than Canada.

Britain's private tier is often pointed to by those in Canada who claim that real market choice doesn't spell the abandonment of the public system. But it's fair to say that private health care in the UK can have a viable economic life only if the public system remains in a shabby state and is generally regarded as second class. There is much talk about strengthening the public tier in the report, but the inherent market requirement for the private tier to perform better draws almost no comment. The report highlights the fall from grace of internal market ideas and the inequities created by contracting with fundholding and non-fundholding GPs, but it does so without directly addressing issues of equity and quality in the public and private financing mechanism.

What is focused on is the need to democratize the NHS, in parallel with the Council of Europe's call for greater citizen participation in health care. An essential recommendation is to give the NHS a constitution to protect its founding principles and guide government policies and practice. Under such a constitution, the NHS would become a public corporation at arm's length from government, with its own board and operational freedom. This is a bold recommendation worthy of consideration in Canada, but perhaps is equally likely to fail miserably on the principal of no taxation without representation.


Fred Sebastian

The commission makes a number of sensible recommendations to ensure that the NHS be made more accountable at the regional and local level by transforming health authorities into elected bodies with a balance of appointments for the sake of expertise. Many of the recommendations are meant to introduce transparency and public right of access to all meetings, minutes and policy papers of executive and advisory bodies within the NHS.

In many respects, what is new about the recommendations is a retreat from the traditions of parliamentary paternalism in favour of a more democratic and transparent approach toward the governance of the NHS. What is striking in this worthy wish for democratic engagement is the absence of any critical reflection on how effective democratic models are elsewhere for institutional and regional governance. In Canada, for example, work by Jonathan Lomas and colleagues has shown that what the public wants with respect to regional authorities (which exist everywhere in Canada except Ontario) is not simply democratic representation but, rather, a balance of expert and clinical inputs and the inclusion of citizens' perceptions and perspectives in the decision-making process.

Another striking aspect of the report is the conservatism of its recommendations with respect to professional self-regulation. Canadian observers noted with some disbelief the granting by the General Medical Council (GMC) in the UK of an unrestricted license to obstetrician Dr. Richard Neale and his subsequent erasure from the registry when several complainants stepped forward. The GMC was aware that Dr. Neale had lost his license in Canada. In the wake of a range of negligent and intentional patient deaths, including the horrific patient poisonings in the case of Dr. Harold Shipman, the British public has been up in arms about how much confidence should be granted to

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the GMC. The Commission on the NHS simply suggests there should be more lay representation on regulatory bodies. This is already the case in a number of jurisdictions in North America and hardly constitutes a bold step forward in professional self-regulation. Hutton applauds the newly established Commission on Health Improvement, the National Institute for Clinical Excellence and adherence to the Patient's Charter as partial answers to the accountability problems in the NHS.

The commission applauds the commitment of the Blair government to improve the base of financial support for the NHS. The British government recently trumpeted a major cash infusion to bring the NHS within reach of the European average in health care spending — promising more than 6% annual growth in real terms over the next four years. While this will go a long way toward relieving some of the current pressures on the UK's health care system, it will fall far short of achieving the objective of meeting the European average in health care spending: this would require roughly a one point increase in overall GDP spending on health care.

An area of glibness in the report is the extent to which it actually wrestles with the difficult issues of trading off "local autonomy and democratic determination" with central policy commitments to equity and public financing. The central role of the NHS is to provide a high-quality base of equitable services for the entire population. This may be difficult to reconcile with a private tier that can exist only by being better than the tier to which all citizens have access as a right. This central–local tension becomes more acute when local authorities choose to restrict access in some specific areas because of local preference, or when they give secondary priority to the aged for a range of life-saving acute care services such as cardiovascular surgery. In other words, how the central government specifies the policy base for what is covered and what is excluded is not easily reconciled with the interpretation of priorities by local authorities on the basis of democratic preference. The commission provides little deliberative reflection on this thorny issue of devolution (which has some parallels pending for Canadians). Saskatchewan's local health authorities are fully elected, an approach that brings its own challenges when concentrated interests seek representation through elected bodies. Alberta has fully appointed boards, well sprinkled with patronage candidates. Lessons may well be drawn from Canada's experience with regionalization and democratization but these will have to await some effective cross-jurisdictional evaluation.

The generous assessment of the Commission on the NHS is that it doesn't try to be more than it is: a progressive reform recipe to democratize the institutional governance mechanisms for Beveridge's great legacy, the NHS.

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One thousand words

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Seasickness experiment, Royal Canadian Navy Medical Research Unit, November 1943